FOR IMMEDIATE RELEASE

North Suburban Regional Human Rights Authority
Report of Findings
HRA # 14-100-9001
Niles Nursing & Rehabilitation Center

In June 2013, the North Suburban Regional Human Rights Authority opened an investigation of possible rights violations regarding Niles Nursing & Rehabilitation Center. The complaint alleges that facility personnel often yell at the residents, facility personnel steal personal items from the residents and medication is not administered as scheduled. Residents receiving services at Niles Nursing & Rehabilitation Center are protected by the Nursing Home Care Act (210 ILCS 45/100 et. seq.).

Niles Nursing and Rehabilitation Center is a 304-bed facility that offers a Korean Program, Dementia Program and a Behavioral Health Program. The Behavioral Health Program is designed to assist individuals and their families in maintaining and improving quality of life as well as enhancing a resident's self-respect and dignity. Niles Nursing & Rehabilitation Center has a team of specialists that works closely with each resident, family member and family physicians or other health professionals to provide the appropriate care each resident needs. Residents are able to participate in vocational programs allowing for an opportunity to earn income and preparing them for community living in the discharge planning process.

Method of Investigation

The HRA reviewed portions of a resident's clinical record, with consent. An on-site visit was conducted in October 2013, at which time the HRA discussed the allegations with the facility's Administrator and the Director of Nursing (DON). The resident whose rights were alleged to have been violated was interviewed by telephone.

Findings

Regarding the allegation that items are often stolen, facility personnel stated that items do, from time to time, come up missing. It was also stated that 95% of the time, the items are found. When items cannot be found, an internal investigation is conducted. It was also stated that recently the facility implemented a "consistent assignment process", meaning that one staff member is responsible for the same resident, thus getting to know what that resident has for personal possessions. It was stated that family members are advised that clothing needs to be marked for identification purposes and that all items need to be inventoried by staff members - but this does not always happen.

The facility provides laundry services and the facility has machines for those residents on the third floor (young psychiatric residents) so that they can do their own laundry. Facility personnel stated that in an effort to prevent residents from pilfering items, a staff member is assigned to

monitor the hallways during meals as that seemed to be a time when residents saw an opportunity to enter rooms undetected.

A review of the resident's grievance forms documented that he alleged that a Certified Nurses Aides (CNA) was smoking his cigarettes. The internal investigative report form showed that the "Immediate Action Taken" was that the CNA was suspended pending the outcome of the investigation. An inventory of the cigarettes was completed and no cigarettes were found missing. The investigation concluded by documenting that the facility inventories cigarettes during each smoking time. An immediate inventory of the cigarettes was completed at the time of the accusation. No cigarettes were identified as being missing. The CNA was interviewed and denied taking any resident cigarettes. It was documented that the resident later recanted the statement, stating that it was his peers that were requesting the cigarettes. The CNA was removed from monitoring the smoking program and was returned to duty.

Another grievance filed by the resident to Administration was regarding missing clothing from the storage area. Documentation showed that the course of the investigation was to interview staff members with access to the storage area. Documentation indicated that the resident was taken to the storage area and found his box of clothes that was taped closed. A staff member documented that it looked like the original tape. The following day it was documented that the resident was again taken to the storage area as he thought that maybe he had another box of clothes, but one was not found. During the site visit, the Administrator claimed, more than once to the HRA - why would we want to steal pants of a 400 lb. man.

A document included in the resident's record was the following statement "even though we are not responsible for missing items, we are reimbursing in full $300.00 to [resident], for items that are missing. This is a confidential matter that should not be brought up to other residents, staff, or visitor of the facility". The statement was signed by the Administrator and the resident. When asked about this reimbursement, the Administrator stated that the resident was reimbursed because he (the resident) had been in the Administrator's office and had reported missing items. According to the Administrator, the resident (the Administrator reiterated the resident's physical size) blocked the door which prevented the Administrator from leaving. The Administrator stated that because the resident was preventing him from leaving his office, the Administrator relented and gave-in to the resident.

Regarding the allegation that staff members often yell at the residents, it was offered that this particular resident talked very loud during an average conversation. When he was upset, which according to staff members was often, he became even louder. It was stated that often staff had to talk loud to him to be heard. Staff members receive training regarding treating resident with respect and are not to yell in anger.

Regarding the allegation that medication is not administered as scheduled, it was explained that residents can "sign-up" for the administration of medication. This means that if you put your name on the list and you are in line for medication, you will be given your medication before any resident that is not on the list. It was stressed that all residents received their prescribed medication and nursing personnel will go to the residents' rooms to dispense medication. The sign up list is for those residents that, for example, want to leave the building at a certain time and do not want to wait. They stated that this resident did not use the sign-up list and thus would have to wait for his medication. It was offered that medication has a two hour window, meaning that it can be given an hour before or after the prescribed time. A review of the record showed that the resident has been diagnosed with diabetes mellitus, benign prostatic hyperplasia, hypertension, hyperlipidemia, chronic lower back and bilateral shoulder pain, left knee replacement, right AKA (also known as) shoulder replacement, hypothyroidism, major depression, chronic obstructive pulmonary disease, bronchitis, seasonal allergy and hypenkalemia. The resident was prescribed medications for his medical and

mental health symptoms. A review of the Medication Administration Records (MARS) showed that various medications were given throughout the day starting at 6:00 a.m. until 9 p.m. The MARs documented that all the medications were administered as ordered. It is noted that the resident upon request, received all prescribed as needed medications. On a very few occasions, it was documented that the resident would refuse the medication and the refusal was honored.

Facility Policy

The facility provided the HRA with a Resident Belongings Storage Flow Chart that documented the following sequence for belongings: **Admission**- items inventoried and clothing treated for precaution. Residents reminded that facility does not replace clothing or valuables and in addition, does not reimburse in cash for loss reports. Residents may lock up or store items. **Labeling** - clothing labeled by CNAs. Newly purchased or additional clothing items brought in are labeled by social services and stored by Resident. **Hospitalization** - CNAs bag clothing and store in storage closet located on the unit. Valuables are stored in the medication room supervised by nursing staff**. Loss Reports/Grievances** - Residents that report missing items fill out a grievance form describing loss (staff assistance where applicable). Appropriate departments receive a copy. Investigation conducted. If found, returned to Resident. If not found, notified that departments will continue to look and return when found. **Laundry** - Laundered clothing is bagged according to name and room number. Clothes are returned to Resident via housekeeping staff. Residents that launder their own clothing are encouraged to ascertain clothing is labeled. **Discharge** - Upon discharge, all items are inventoried, if applicable, items accompany Resident; otherwise items are stored and arrangements are made between facility and new placement to deliver or pick up items.

The facility's Drug Administration - General Guidelines policy states (in part) that medications are administrated as prescribed, in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medication do so only after sufficient information regarding the resident's condition and expected outcomes of medication therapy is known. The licensed nurse is aware of an indication for resident receiving medication, usual does, parameters and routes, contraindications, allergies, sensitivities, and side effects.

The facility's Abuse Prevention Program policy states (in part) that mental abuse includes but is not limited to humiliation, harassment, threats of punishment or withholding of treatment or services. The policy states that on a periodic basis but not less than annually, staff will receive a review of the above topics [physical, mental, sexual, verbal abuse; neglect, mistreatment, and misappropriation of resident property]. On a periodic basis, Supervisory personnel will receive training on their obligations under law when receiving an allegation of abuse, neglect, mistreatment, theft and how to monitor and correct inappropriate or insensitive staff actions, words or body language.

Statutory Basis

Pursuant to the Illinois Nursing Home Care Act, Section 2-103, "A resident shall be permitted to retain and use or wear his personal property in his immediate living quarters, unless deemed medically inappropriate by a physician and so documented in the resident's clinical record. If clothing is provided to the resident by the facility, it shall be of a proper fit. The facility shall provide adequate storage space for the personal property of the resident. The facility shall provide a means of safeguarding small items of value for its residents in their rooms or in any other part of the facility so long as the residents have daily access to such valuables. The facility shall make reasonable efforts to prevent loss and theft of residents' property. Those efforts shall be appropriate to the particular facility and may include, but are not limited to, staff training and monitoring, labeling

property, and frequent property inventories. The facility shall develop procedures for investigating complaints concerning theft of residents' property and shall promptly investigate all such complaints."

Pursuant to Section 2-104 of the Nursing Home Care Act, "(b) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders."

Pursuant to Section 2-107of the Nursing Home Care Act, "An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. It is the duty of any facility employee or agent who becomes aware of such abuse or neglect to report it as provided in "The Abused and Neglected Long Term Care Facility Residents Reporting Act".

Investigative Conclusion

The facility reimbursed the resident for missing items; the Administrator stated that the reimbursement was made because the resident was blocking the door preventing the Administrator from leaving his office. It is concluded that the reimbursement was evidence that the facility accepted responsibility for missing items. The allegation is substantiated. No recommendation is made since the matter was resolved.

Based on the information obtained, nothing was found to show that medication is not administered as scheduled or that staff members yell at the residents.

Suggestion

It is strongly suggested that staff members receive **extensive** training regarding serving persons with mental illness. To say that a monetary reimbursement was given simply because a resident was unmanageable does not help that resident deal with his behavior symptoms.

Nursing home leadership should be cognizant of references made to staff or others about residents' personal characteristics, including size, as such comments could be considered derogative and inconsistent with a resident's right to be treated with dignity and respect.